

**IMPLEMENTATION EVALUATION OF
THE DISTRICT OF COLUMBIA *PUT*
FAMILIES FIRST PROGRAM**

The Urban Institute

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Executive Summary

The goal of this evaluation was to understand the planning, implementation, and execution of the Put Families First program as it is administered by Functional Family Therapy (FFT) in the District of Columbia (D.C.). The primary question is whether FFT has been implemented with high fidelity and quality, and whether there are local factors or circumstances that either facilitate or interfere with its reliable implementation.

This evaluation reviewed programmatic manuals and materials, engaged in semistructured interviews, analyzed performance data, and scanned the extant FFT programmatic and outcome literature. Through these activities, this report documents how the program came together, identifies its key stakeholders and their role in the process, and uses performance data to examine how the program appeared to be progressing along a number of key measures.

Management oversight and buy-in are key qualities that the program already possesses. Evidence-Based Associates, LLC (EBA) guided the original planning discussions, led troubleshooting efforts as barriers arose, and attempted to look to the future to anticipate and avoid future problems and institute changes that would be beneficial moving forward.

The program partners were all committed to the program; they identified representatives that had leadership and supervisory roles in their respective agencies and had the authority to implement change. Commitment and belief in the model and its implementation are critical factors.

The implementation results to date suggest that the FFT program was implemented rigorously and is on its way to effective implementation, but has some challenges yet to overcome. The apparent differences between service providers offer an obvious starting point for inquiry to identify opportunities for such improvement.

The current implementation evaluation shows promise for the effective implementation of FFT for youth at risk of out-of-home placement in D.C. For those who do complete the program, implementation is generally close to program benchmarks and showing improvement. Some areas needing improvement were also identified, especially concerning the program's ability to engage and retain the referred youth through program completion, and understanding the reasons for agency referrals.

Prior evidence of program effectiveness in reducing delinquency suggests that the current program has strong potential for being an effective part of the service mix for these youth and their families.

Future evaluation activity should continue to focus on improving program initiation, effective implementation, and program completion. This would then set the stage for either a rigorous impact evaluation or a cost-benefit analysis based on combining local cost analysis with evidence of program effectiveness from prior evaluations of FFT.

1. Introduction

In 2009, the District of Columbia Justice Grants Administration (JGA) funded the Put Families First (PFF) program. The goal of the PFF program was to prevent out-of-home placement of youth as well as to serve as a source of support and stabilization for youth returning from out-of-home placement. To accomplish this goal, the PFF program selected an evidence-based program, Functional Family Therapy.

Functional Family Therapy (FFT) is a family-based prevention and intervention program that treats at-risk youth and youth who have had previous contact with the juvenile justice system. Through a series of therapeutic sessions designed to increase protective factors while reducing risk factors, the ultimate goal of this therapy is to mitigate the risk for future delinquency and address family issues in order to reduce youth (re)offending (Sexton and Alexander 2000). FFT has a specified model and training program for sites and clinicians. Official FFT providers must also obtain training and consultation from an FFT Inc. consultant during the course of the program's implementation.

FFT has been evaluated through a number of randomized controlled trials confirming its ability to reduce reoffending. It is administered in the home, typically to adolescents and their families. The therapy spans three to four months, with 12 to 14 one-hour sessions with a trained FFT therapist, the youth, and family.

In the PFF program, youth are referred to FFT from three agencies: the Department of Youth Rehabilitation Services (DYRS), the Child and Family Services Agency (CFSA), and the Department of Human Services' Parent Adolescent Support Services (PASS) program. These agencies refer youth to one of two FFT service providers participating in the PFF program, based on geography. The Progressive Life Center (PLC) serves youth residing in Wards 1 through 6. Student Support Services (SSC) serves youth residing in Wards 7 and 8.

Evidence-Based Associates, LLC. (EBA) oversees all phases of the process from how youth and families are identified to their actual referral and receipt of functional family therapy services. In December 2010, EBA contracted with the Urban Institute's Justice Policy Center to conduct an implementation assessment of the PFF program.

THE IMPLEMENTATION EVALUATION

This implementation evaluation assesses the PFF program's planning, implementation, and fidelity to the FFT model. A complementary evaluability assessment memo, attached separately, examines the program's potential for a future impact evaluation. The evaluation draws on three

major sources of information: program materials, stakeholder interviews, and aggregate program performance data discussed below.¹

- Review of program materials—Urban Institute (UI) researchers reviewed PFF program materials, including program manuals, training guides, assessment and evaluation protocols, and all formal procedures for assessing adherence to the FFT design. These documents articulated the PFF program vision and how it developed over time. They also provided initial benchmarks on which the program might be assessed. For example, the program intended to serve 200 families (approximately 100 per service provider) during its two years of operation.
- Semistructured interviews with program stakeholders—UI researchers spoke to all PFF staff responsible for the program's design, implementation, and oversight. These interviews examined the role stakeholders and staff play within their organizations, where they fit in the PFF program processes, and how their organization became involved with the program. In addition to discussing the historic, organizational, and design aspects of the program, the interviews also asked questions about the program's activities. This portion of the interview discussed how cases were actually handled in the organization, including eligibility criteria, the use of assessments, and interaction with families. These discussions identified important successes or strengths of the program and illuminated programmatic obstacles and if and how they were addressed.
- Aggregate program performance data—UI researchers reviewed three types of performance data for the program, maintained by PFF partners. This included EBA's monthly referral census, FFT's Clinical Services System data, and case-level information from each of the two service providers. While UI attempted to obtain case-level information from the referral agencies for this evaluation, DYRS and CFSA were unable to provide these data and PASS was migrating to a new electronic system, which raised data integrity issues.

THE FUNCTIONAL FAMILY THERAPY MODEL

FFT is a family-based systems approach developed over the course of more than 30 years, principally by Dr. James Alexander. In the past decade, implementation of FFT has grown from approximately 30 programs in the early 2000s to over 200 programs across the United States in 2010. It has been implemented in several other countries outside of the United States, collectively serving tens of thousands of families across the world each year.²

FFT focuses on enhancing communication between the youth and participating family members and on strengthening and increasing protective factors, while limiting and reducing risk factors, in order to reduce future delinquency. The primary population is at-risk youth who have not had

¹ UI also proposed to conduct focus groups with families participating in the PFF program, intended to explore families' motivations for participating in the therapy, whether they felt they were benefitting from that participation, and benefits and challenges they experienced. Unfortunately, too few families were willing to participate to make these focus groups viable.

² See the FFT program web site at <http://www.fftinc.com/sites.html>.

previous contact with the criminal justice system and, secondarily, on those youth who have had prior or current contact with juvenile justice or family service agencies.

Over approximately 12 to 15 weeks, FFT encompasses three distinct phases with goals of increasing hope, building alliances, and decreasing blaming and negativity within participating families. Overall, these three phases—Engagement/Motivation, Behavior Change, and Generalization—use a variety of techniques to interrupt negative, harmful behaviors and replace them with positive, prosocial behaviors among youth.

Phase 1 – Engagement/Motivation (4 to 6 weeks): This phase focuses on building trust, responsibility, credibility, and rapport between the youth, their family members, and the therapist. The family is typically one or more of the youth's parents; however, it can include anyone that is particularly influential or important in the youth's life. In this phase, the therapist works to protect against the blaming or labeling of the youth for prior behavior³ and to demonstrate that sessions will not consist of an alliance between the family and therapist. During this phase, the therapist also attempts to dispel preconceived notions about the substance of future sessions and open up the families (adults and youth) to understanding their roles in the family dysfunction and changing their actions in hopes of better results.

Phase 2 – Behavior Change (4 to 6 weeks): This phase focuses on skill-building to address the behavior that led to the youth's referral to FFT, which is often one of many components of negative activity, emotion, or behavior happening in the home. The therapist then works with the family on how to respond to and deal with those actions while immediately reinforcing the positive and protective factors that are present in the family. Chronic, habitual, and problematic interactions between the youth and family may necessitate considerable attention aimed at structuring, teaching, and organizing the skills being communicated to the families. Engagement/motivation targets the underlying symptoms of the behavior; once they are addressed, the Behavior Change phase can focus on changing the interaction between family members to make it more positive and healthy. The therapist observes success through changes in the referral behavior, whether it be substance abuse, truancy, or instances of violence. This phase requires the therapist to delve deeply into the family's activities to identify what behaviors could be adapted for more positive outcomes and to determine the success of these changes. As these are typically chronic behaviors, short-term changes do not always translate into truly changed behavior; thus, therapists are mindful of checking in on the changed behavior throughout this and the following phase.

Phase 3 – Generalization (4 to 6 weeks): This phase ensures that the youth and family have the potential to maintain/continue the strides made in therapy even after FFT concludes, improving their resilience to future difficulties. The therapist works to connect the youth and family to external resources (individual therapy, mentoring, etc.). These additional services should reinforce skills learned during previous phases and even build new skills. However, the main component of this phase is to demonstrate how these skills can be applied to social interactions external to the family dynamic. Families should also demonstrate stability and independence within the family, demonstrating the ability to adapt to new problems as they arise with minimal coaching or direction from the therapist. It is important to consider that there are also negative social and environmental influences that can be affecting the youth and family.

³ Note that FFT distinguishes *blame* from *responsibility* and works to reduce blame while retaining responsibility.

Thus, part of the goal for this phase is to identify these triggers and devise ways to prevent relapse from the negative influences. After successful completion, it is also possible for a youth and family to have a “booster session” (on family request).

The typical time a family receives FFT, from their beginning to end, is approximately 12 to 15 weeks. Once receiving a referral for FFT services, the intention is for a provider to contact the family within 48 hours and schedule their first appointment. A full caseload for a clinician is approximately 10 cases at varying phases within the FFT model. Typically, there is some initial time where service providers start below capacity with fewer cases—when in the initial, more intensive and critical Engagement/Motivation phase—and then proceed to add additional cases as those initial families move on to later phases.

SUMMARY OF PRIOR EVALUATIONS

Since its inception in the early 1970s, FFT has been subject to a number of evaluations (see Aos et al. 2001), and has been shown to be successful for a diverse group of youth with various problems (e.g., truants, runaways, and those with drug and/or violence issues). These findings have led to FFT being named a model program by the Blueprints for Violence Prevention project.⁴ To be accepted as a “Blueprints” program, a program must meet several core criteria. It must demonstrate positive effects from a strong research design (experimental or strong quasi-experimental), low rates of attrition and adequate measurement, statistically significant deterrent effects that were sustained posttreatment, and replication in multiple sites (Alexander et al. 1998). The design, subjects, and outcomes of previous FFT evaluations are shown in Appendix A: Prior Evaluations.

Evaluations of FFT usually report both social outcomes and recidivism. FFT has been found to increase communication skills (Alexander 1971; Alexander and Barton 1976, 1980; Parsons and Alexander 1973), increase parental involvement (Friedman 1990), and to reduce out-of-home placements (Barton et al. 1985). Among recidivism rates, programs report reductions ranging from approximately 20 to 50 percent when rated against comparison groups of varying compositions. Follow-up time after treatment completion varies. In most evaluations, follow-up exceeded one year postcompletion. Several evaluations have followed youth and families for more than 18 months following the therapy.

It is worth noting that prior evaluations are primarily focused on delinquent youth, with some examining the effect of FFT on youth with histories of substance use. In the PFF program, these would be most similar to the youth referred by DYRS. Although the literature is not as strong with nondelinquent youth, some evaluations have focused on FFT services to youth referred through human and social services agencies (Regas and Sprenkle 1982). These youth would seem to be comparable to the youth referred to PFF by CFSA (child welfare) and the Department of Human Services’ PASS program (status offenses).

⁴ In addition to FFT, the remaining model programs are Nurse Home Visitation, Bullying Prevention Program, Promoting Alternative Thinking Strategies, Big Brothers Big Sisters of America, Quantum Opportunities, Multisystemic Therapy, Midwestern Prevention Project, Life Skills Training, and Multidimensional Treatment Foster Care.

2. The PFF Program Model

Once the initial referral agencies and service providers joined the PFF program, the initial work among the PFF program partners involved formulating the referral process, which took several months to complete. After extensive consultation and planning with all partners, EBA developed the Policies and Procedures manual outlining referral process and creating program goals. This implementation manual is included in Appendix B.

PROGRAM COORDINATION AND OVERSIGHT BY EBA

Evidence-Based Associates, LLC (EBA) serves an oversight and coordination function for the entire PFF program. EBA specializes in administering a small set of proven, evidence-based programs through performance-based contracts with juvenile justice agencies. EBA has a longstanding relationship administering FFT in Florida, where it oversees the statewide implementation of the model. EBA also provides services to jurisdictions interested in offering Multisystemic Therapy and Multidimensional Treatment Foster Care, both of which are recognized as evidence-based programs. EBA was contracted by the JGA to implement FFT in Washington, D.C. through the PFF program. Although outside of the scope of this evaluation, EBA also managed the launch of FFT through D.C.'s Department of Mental Health.

EBA designed the PFF program with the program partners, authored its Policies and Procedures manual, and manages the partnership among PFF's various partners. Each month, EBA facilitates a conference call in which all of the PFF stakeholders participate. Stakeholders include representatives from the three referral agencies, the two service providers, the two lead entities, FFT Inc., and the JGA.

EBA's oversight role is dynamic; it involves engaging in strategic planning throughout the course of implementation to anticipate and address potential obstacles, as well as to respond to implementation barriers as they arise.

IDENTIFYING, REFERRING, AND SERVING ELIGIBLE YOUTH

The PFF program offers FFT to youth age 11 to 18, who are residing at home or are within 60 days of returning to their home (youth identified by CFSA also had to have a home placement rather than an alternative such as foster care). Youth diagnosed with severe mental illness, those who have committed sexual offenses without treatment, and youth already engaged in some form of family therapy are ineligible to receive the therapy. However, youth with less severe mental health problems and those receiving individual therapy may still be eligible to receive FFT.

PFF was initially envisioned as targeting delinquent youth from the Department of Youth Rehabilitation Services (DYRS) and Court Social Services (juvenile probation) in the Superior Court of D.C. Both DYRS and CSS have supervision over delinquent youth in D.C. EBA was able to engage DYRS, but was unable to persuade CSS to join the program. Therefore, to supplement the referral numbers, EBA identified the Child and Family Services Agency (CFSA) as a possible source of youth who would benefit from FFT. While some of these youth have had prior contact with DYRS or CSS, most are at-risk for future system contact rather than having been previously adjudicated delinquent.

In the program's second year, EBA explored opportunities with other D.C. agencies to identify an additional referral source of appropriate youth for PFF. The Department of Human Services' Parent & Adolescent Support Services (PASS) program was added as a third referral source.

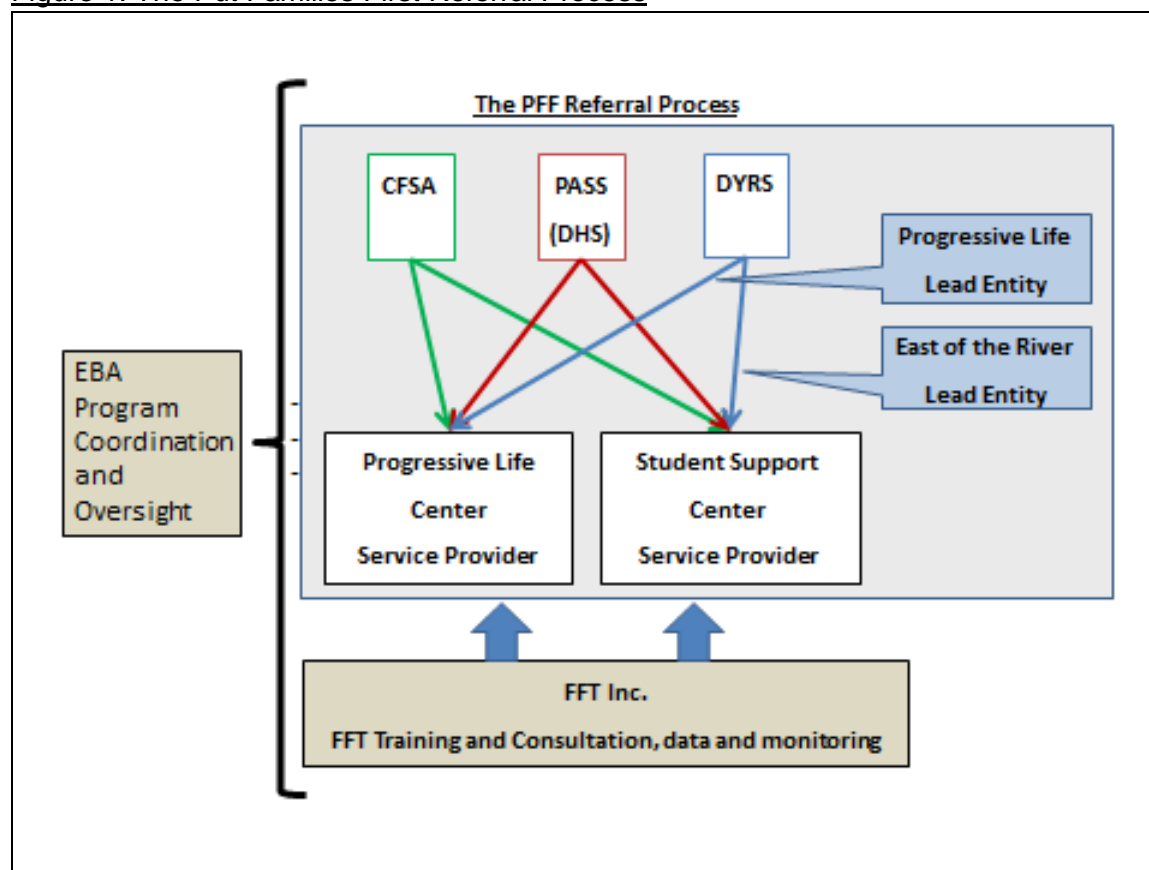
Each of the referral agencies conducts similar activities in identifying youth for suitability for FFT. First, they assess youth and family needs and review their background to determine the appropriateness of FFT and/or other services, to improve functioning and reduce negative behavior. Each referral agency uses its own assessment form to document youth and family needs, family desires, risk factors, and previous interaction with D.C. agencies.

Once a referral decision is made, the second step is for agencies to contact the service providers, PLC and SSC, to provide background to therapists. When making a referral, agencies are to provide valid contact information to service providers to facilitate session scheduling, background information on the youth and family to assist the therapist in planning for the content of sessions, and a list of other services being received by the family. The agencies also assist the therapists if they are unable to reach or engage families, and to coordinate the case management process, especially when the youth and families are referred to multiple service providers. Referring agencies provide the initial introduction to the service to families, informing them on how the therapy operates, its goals, and the program expectations to which the families are expected to adhere.

After receipt of the referral from the agencies (or from one of the two lead entities under DYRS), the service providers confirm that the referral is appropriate. For all appropriate referrals, a therapist is assigned. The youth should be contacted by the service provider within 48 hours and the first FFT session should take place no later than one week after referral. The goal is for cases to have 10 to 12 one-hour sessions over three to four months.

The general referral process is depicted in Figure 1.

Figure 1: The Put Families First Referral Process



REFERRAL AGENCIES

Each of the referral agencies, and its particular referral process, is described below.

DEPARTMENT OF YOUTH REHABILITATION SERVICES (DYRS)

The Department of Youth Rehabilitation Services (DYRS) is the primary juvenile justice agency in D.C. Once a youth is adjudicated delinquent, the court may commit that youth to DYRS custody.⁵ DYRS has discretion over particular placements, which include secure facilities (New Beginnings), as well as various community placements, including residential placement outside of the home, and home placement. DYRS stresses a rehabilitative model of care, involving

⁵ DYRS also maintains a juvenile detention facility (the Youth Services Center) for youth requiring detention before adjudication and disposition. However, detained youth are not eligible for the PFF program at this time.

programs and educational opportunities that stress positive change and skill-building. DYRS places many committed youth in residential treatment centers and/or under residential supervision in the community. Youth are also assigned to various programs and services, including evidence-based programs such as FFT. DYRS youth in the community or those soon to be released into the community may be referred to FFT.

DYRS uses the Youth-Family Team Meeting (YFTM) to help decide the proper placement and services for each youth in the community.⁶ Before the YFTM, DYRS consults a risk-offense matrix, conducts mental health screenings to assess needs, examines the youth's history for previous treatment failures or successes, and tries to consider what it believes is the risk for reoffense. Present at this meeting are YFTM facilitators, coordinators, and potentially other DYRS staff, the youth, the youth's family, and any other influential people in the young person's life. A plan is devised for each youth based on his or her needs. The typical YFTM begins 30 days before the youth is to return to the community. FFT is one service that may be considered at the YFTM.

A representative from one of two DYRS lead entities (described below) also attends the YFTM. If FFT is deemed appropriate, and the youth and family agree to participate, a DYRS case manager and representative from the lead entity generate a referral form without which services cannot be provided. The referral form serves as a synopsis of the service recommendations as well as any monitoring suggestions. Once this is completed, the services are uploaded into the DYRS database (called YES) by DYRS staff, and the lead entity refers the youth and family to the service provider.

Lead Entities

In 2009, DYRS began using two geographically based agencies to coordinate services received in the community, which they call "lead entities". The lead entities coordinate a coalition of service providers located within a geographic area. The purpose of the lead entities is to provide consistent and accessible services that are more geographically proximate to youth and families in the belief that greater ease of access would result in more frequent use of services.

In the referral process *per se*, the lead entities have essentially a pass-through and coordination function. DYRS provides that referral to the lead entity, which is then charged with coordinating services for the youth. The ultimate decision to refer a youth to FFT is made by DYRS rather than the lead entity.

The DYRS lead entity serving youth in Wards 7 and 8 is the East of the River Clergy-Police-Community-Partnership (ERCPCP). Their service provider coalition includes approximately 40 organizations that provide eight different categories of services. ERCPCP trains these organizations, establishes memoranda of understanding (MOUs), engages in capacity-building efforts, and educates coalition members about DYRS, its mission, and its youth. ERCPCP maintains active caseloads of approximately 280 youths per week. ERCPCP uses a quality assurance program to ensure that coalition members are compliant with lead entity policies and that services being employed are both appropriate and beneficial for the youth. After receiving

⁶ DYRS instituted the YFTM in 2008. Before, case management had largely consisted of the case manager unilaterally making treatment and service decisions. That approach was abandoned for the YFTM's more inclusive style of decision-making, focusing on the youth and family as active participants in the placement of the youth on a more prosocial pathway.

and reviewing FFT referrals, ERCPCP turns the referral over to their FFT service provider, the Student Support Center (SSC), as described below.

The lead entity serving youth in Wards 1 through 6 is the Progressive Life Center (PLC). PLC has a designated coordinating director for its lead entity responsibilities, who develops and manages policies and procedures and supervises staff and case closures. The director also oversees the coalition of organizations providing services under the lead entity program and helps administer services for providers beyond the funding with which lead entities are provided. PLC receives and reviews FFT's referrals to ensure that youth are appropriately referred.

PLC serves a dual role. In addition to its role as a lead entity, it also is the FFT service provider for youth in Wards 1 through 6. The organization maintains these elements separately to ensure continuity among themselves and for the organization of the other coalition service providers.

CHILD AND FAMILY SERVICE AGENCY (CFSA)

The Child and Family Service Agency (CFSA) is the second source of referrals for the PFF program. CFSA is the District's child welfare agency that is charged with the safety, protection, and well-being of resident youth and families. CFSA investigates reports of child abuse or neglect. When such reports are made, CFSA social workers investigate claims for their veracity and determine services that the youth or family might need. When remaining in the home appears dangerous for the youth, CFSA arranges for temporary supervision of the minor and decisionmaking power over the youth is vested in the Family Court. In such cases, social workers seek to provide services that could ultimately lead to family reunification; however, in cases where this is not possible, CFSA attempts to establish permanent out-of-home placements that will provide support and care for the youth.

CFSA uses Family Team Meetings (FTM), in which coordinators assess the youth and family to determine their service needs. Ideally, the youth and family are engaged before the meetings. However, it is at the meeting that the actual referral for services occurs. During the meeting, the coordinator reviews the youth and family history and discusses options and preferences. Youth-family goals, family dynamics, past contact with juvenile justice or other agencies, mental health diagnoses, and past and present at-risk behavior are among the factors considered during the FTM coordinator's assessment and discussion with the family.

Once FFT is identified as the most appropriate service and the youth and family agree to participate, the referral is initiated through the completion of the Behavioral Services Unit Referral form, and referrals for FFT are forwarded to CFSA's Office of Clinical Practice for review. The youth's file and referral is reviewed for completeness and appropriateness before being forwarded to either PLC or SSC based upon the family's residence (PLC serves Wards 1 through 6 and SSC serves Wards 7 and 8).

CFSA remains involved in the case after FFT is initiated. A CFSA case manager is assigned to each case, receiving information from the service provider about the progress of the treatment and working with the provider to troubleshoot problems as they arise.

PARENT & ADOLESCENT SUPPORT SERVICES (PASS), DEPARTMENT OF HUMAN SERVICES

The Parent and Adolescent Support Services (PASS) program within the Department of Human Services was launched in May 2010. It focuses on connecting at-risk youth—usually status offenders—with services. Status offenses are activities that are illegal only because of the age of the individual engaging in those activities (e.g., truancy, curfew violations, running away from home). The goal of the PASS program is to replace negative and unhealthy behavior with positive behavior, increase family functioning, and to keep youth from future contact with the juvenile justice system and child welfare agencies. PASS was interested in FFT because of its focus on at-risk, intact families that are in need of services.

Most PASS youth are diverted, as a prosecution alternative, from the Metropolitan Police Department, D.C. Office of the Attorney General, or from Court Social Services (juvenile probation). PASS also accepts youth from CFSA, who are often referred to their care because of truancy, youth who typically have little or no past criminal or delinquent experiences.

During an initial series of meetings with PASS case workers, the parent and youth complete assessments identifying needs, problems, desires, past diagnoses, and other questions that PASS case managers use to identify the best suite of services for the youth and family. The assessment evaluates the youth's psychological and mental health and behavioral components, resulting in a set of potential options for the youth and family to agree to pursue. When it is determined that FFT is the most appropriate treatment and the family agrees to participate, the PASS case worker makes a referral to one of the two service providers. The case worker interacts directly with either PLC or SSC in making the referral, choosing among them based upon the same geographic boundaries identified for DYRS and CFSA referred youth.

After referral, a PASS case manager remains in contact with both the family and the provider throughout their receipt of services. This typically spans three to five months. There is no set guideline for how often or when case workers should reach out to families before, during, and after services. Case managers have the flexibility to monitor the situation, visiting the family at their home or the youth at school, to check in. They may sit in on sessions or meet with the youth's teachers and others in contact with the family to increase their connectedness and familiarity with the family situation and its progress.

SERVICE PROVIDERS

FFT is provided through two service providers. Regardless of the referring agency, youth residing in Wards 1 through 6, as well as those committed to CFSA or DYRS care in Montgomery County, receive FFT from the Progressive Life Center (PLC). Youth residing in Wards 7 and 8, or committed to CFSA or DYRS care in Prince George's County, receive FFT from the Student Support Center (SSC).

PLC built its FFT program in 2009 when the JGA provided funding for the PFF program. PLC did not have previous experience providing FFT. PLC is in a unique position as both a DYRS lead entity and a service provider. Though PLC is also a DYRS lead entity, PLC's lead entity and service provider components operate separately, even though they use the same facilities and exist under the same organizational leadership.

SSC had previous experience with offering FFT in D.C., with funding from the D.C. Children's Trust. The Trust was able to commit to one year of funding that facilitated SSC therapist training, but it was unable to sustain the program for the long term. Before the PFF program began, SSC focused on providing services to front-end youth, later expanding to students and schools, working with problems such as truancy issues.

The service provider organizations include therapists, team leaders (who also have active FFT caseloads but at a reduced level), and program directors. Program directors have oversight, administrative, and budgetary responsibilities and also manage the FFT clinicians. In addition, program directors engage the other participating PFF stakeholders and review the clinical intake, assessment, and referral documents to ensure that referrals are appropriate. FFT team leaders have supervisory responsibilities that include providing clinical supervision, ensuring that agency referrals are appropriate, supervising clinician caseloads, leading team meetings, reviewing clinician session logs, and entering case data into the FFT case management system. Initially, FFT consultants serve as team leaders, and this responsibility is handed over to the service providers by the end of their first year (discussed below).

CONSULTATION, TRAINING, AND MONITORING FROM FFT INC.

FFT Inc. was founded in the late 1990s to provide training and consultation and to ensure fidelity to the FFT model and quality of FFT services. FFT Inc. staff train therapists new to FFT and consult with service providers through the course of their use of FFT. In addition to these quality-assurance activities, FFT Inc. staff also conduct analyses using service provider data to promote continued understanding of the effectiveness of FFT.

REVIEWING SERVICE PROVIDER APPLICATIONS

A consultant from FFT Inc. was among those who reviewed applications submitted by potential service providers to JGA interested in administering FFT for the PFF program. This involvement of FFT Inc. early in the PFF program is atypical as FFT Inc. usually finds out about such grants after they are awarded. This early involvement allowed FFT Inc. to examine the organizational capacity and mission of the applicants to help identify organizations whose philosophies best complement the FFT model. This early involvement was intended to support better program implementation.

TRAINING

To ensure that sites implement FFT with fidelity, FFT Inc. requires service providers interested in implementing FFT to receive training and consultation with FFT Inc. for as long as the provider continues to offer the FFT service. While therapists are required to hold a bachelor's

degree, the FFT model does not strictly require it. Many FFT clinicians have a master's in social work or another associated field.⁷

Like the FFT model itself, FFT Inc. uses a phased approach for therapist training. Phase 1 of the training takes approximately one year to complete. The proposed FFT team receives initial and follow-up clinical training from their FFT consultant, as well as consultations with the FFT team members weekly. While training is technically ongoing, the team begins taking on active caseloads after the initial therapist training. The consultant returns every three months for additional training. After the fourth training session, which typically marks one year since the site began its FFT training, the time between the sessions is extended to six months. Toward the end of Phase 1, a team leader is selected out of the FFT team and that individual participates in additional trainings.

Phase 2 (which is the current phase for both SSC and PLC) includes an annual site visit and training with the FFT Inc. consultant and phone conferences twice per month between the site team leader and consultant. At this point, the team leader is managing the weekly team reviews and meetings that the FFT consultant would have led in Phase 1. Nevertheless, the consultant will listen in on three team meetings throughout the year as a quality check. Before leaving Phase 2, the team leader receives a second supervisory training. If at any point the FFT team loses 50 percent or more of its therapists, it is commonly recommended that the team start again at Phase 1, as past experience has demonstrated this is often too hard and/or overwhelming for therapists to be thrust into an advanced phase without the proper initial foundation.

Phase 3 is the last phase and it is ongoing. It is a maintenance phase that includes one call per month with the team leader, one site visit per year, and three phone conferences where the consultant listens in to the weekly therapist meetings.

During the training sessions, therapists are provided with protocols to follow and techniques to employ given their assessment of what the family or youth needs or demonstrates they want during their sessions. The FFT therapist training explains the FFT model (engagement/motivation, behavior change, and generalization) and, within each of the phases, discusses the primary points of focus for the therapist and how to observe cues from the youth and family members to inform next steps. Each phase also has a series of skills or techniques that reinforce the phase goals. For example, a therapist might employ a "reframe" whereby the therapist acknowledges the negative emotion or viewpoint as described by a family member, but also proposes an alternative motive for that type of behavior, one absent the negativity or ill will that the family member feels. While the therapeutic approach does contain specific objectives, it is meant to be flexible as well. The therapist takes feedback from what he or she is hearing and seeing during sessions, using that information to help reorganize the approach for subsequent sessions. If a technique fails or meets resistance with the family, it is noted and another technique is used. The training also stresses therapist organization. Before each phase begins, the therapist outlines the strengths, weaknesses, goals, and needs for the overall phase and the next session in detail. After each session, the therapist updates the case notes and the next

⁷ FFT Inc. seems to believe that those who do not have a long history in providing an alternative therapy typically grasp and adhere to the model better than those who must transition from a completely different approach to therapy.

session's plans. FFT's push for preparedness promotes flexibility within sessions as the therapist is armed with a number of options for the preidentified needs of the family.

CSS DATABASE

FFT Inc. designed its Clinical Services System (CSS) database to allow therapists to easily track case information and for FFT Inc. to routinely track and analyze actual FFT implementation and progress. Therapists enter a series of assessments that are administered throughout the engagement period along with case notes that include concerns or potential threats the therapist observes and goals and techniques to be employed at the next session. The FFT consultant and the site's team leader use the database to track case progress and therapist adherence and fidelity to the model. In this way, the database is used as a quality assurance tool, indicating whether a therapist needs additional assistance or guidance.

3. Implementation of the PFF Program

For this implementation evaluation, UI conducted semistructured interviews with 21 stakeholders and practitioners involved in the PFF program. UI staff also attended DYRS case manager and YFTM facilitator meetings where the program was discussed, attended FFT Inc.'s initial therapist training session, and observed the regular monthly calls with stakeholders that were convened by EBA. These activities generated information on a number of implementation challenges and changes encountered by PFF. Note that the implementation evaluation of PFF was launched late in the first year of PFF's operations. As such, UI's reporting on initial implementation and changes made earlier are necessarily both indirect and retrospective.

PROGRAM COORDINATION

- Each month, EBA facilitates a conference call in which all of the PFF stakeholders participate. These conferences were originally used to make early programmatic decisions, such as the specific referral population, the particular structure the service would take, and various other logistical issues. Once the program became more established, these calls focused on the referral progress from each of the agencies, any barriers to getting youth referred to the program, providers' space issues/wait list, any delays in scheduling initial visits, communication among the partners, and grant issues from JGA.
- Any program will have its share of problems, especially when it is newly introduced to referral agencies. Selling it to families and to service providers who had not previously offered the service also presents its own challenges. Stakeholders believe EBA's management identified problems early and led to solutions that were actionable and enduring. They also cite the value of the monthly stakeholder meeting as important; having all of the partners engaged and participating and offering varied perspectives helped the program reach effective conclusions.
- At program inception, there was a lack of clarity as to what information was collected at what stage, by which partner, and transmitted to whom. For example, service providers found contact information obtained from referral sources to be incomplete or inaccurate at times. A commitment to improved communication and instituting quality assurance checks has helped improve the early deficiencies in the administrative process.

THE REFERRAL PROCESS

- The PFF program intended to serve 200 families over a two-year period. It referred over 300 families and served over 170. While the program fell short of its goal of serving 200 families, many of the families referred but not served involved youth that were administratively discharged or placed out-of-the home.
- Referral agencies report that the process has largely been implemented as originally designed.
- Many families referred to services are resistant to them, particularly therapy. While therapists strive to be relentless and engaging, referral sources need to better inform families about what FFT is and persuade them to participate.
- DYRS youth can be referred to FFT with 60 days remaining in their confinement, and therapy can begin while the youth is still in confinement. Staff report that referral is typically within 30 days of anticipated release and that treatment generally does not begin until the youth returns home.
- Youth referred to FFT from CFSA are under protective supervision—none of them are committed clients—and most referrals to CFSA are for educational reasons (e.g., the youth is chronically truant, skips classes, or has overall low attendance, etc.). When this happens, the school is required to report it to CFSA for possible educational neglect.
- Occasionally, the youth referred to FFT have come to CFSA attention because of possible physical abuse (as reported by youth) that is later determined to be unfounded. In these instances, such accusations indicate problems within the family relationship and communication dynamics, and FFT is seen as an appropriate referral for the family issues.
- A key difference between PASS and DYRS or CFSA is that most youth and families referred to PASS are engaged with the entire program voluntarily. In contrast, youth under DYRS and CFSA supervision may be required to accept or receive services, although each particular service is typically voluntary.
- In the event that the number of referrals and active cases exceed capacity, service providers create a waiting list. The waiting list is organized both by length of time on the list and need. Families on the list the longest and those that present the greatest need for the therapy with no suitable service alternatives typically receive the next available slots from providers. This decision is made in coordination with the referral sources.
- Service providers began forming waiting lists in the program's second year; each provider consistently had between 2 and 11 families waiting to begin the therapy.

REFERRAL CONSIDERATIONS

- Early on, referral agencies were unclear regarding all of the eligibility criteria. For example, staff report that youth who were engaged in individual therapy were being excluded from FFT, although they should remain eligible as long as the other therapy is not family-based. After being discussed during one of the monthly PFF stakeholder calls, the situation appeared to have improved.

- At program inception, referral agencies lacked the familiarity with FFT to make referral decisions with confidence. They continued to refer to services that had been previously available until they had a better grasp of the therapy's goals and youth-family factors that would make them more likely to succeed in FFT. After this issue was discussed at length over several stakeholder calls and service providers visited referral agencies to discuss FFT in greater depth, the situation seemed to have been resolved.
- Lack of certainty with the treatment led to higher numbers of inappropriate referrals that dropped once the case managers making referral decisions became more comfortable with FFT.
- As coordinators and managers in the referral agency learned about and become more comfortable with FFT, they began to explain and champion it more in team meetings.
- Youth and families often satisfy the criteria of several DYRS service providers and the decision to refer a youth to one program over another was difficult.
- The eligibility criteria for FFT seemed broader than for some other offered services.
- Because FFT is conducted at home, it seemed less intrusive than some alternatives.
- Capacity to act on new referrals promptly was among the factors being weighed. In some instances, a referral to a service deemed less suitable was more desirable over a youth being placed on a waiting list for a better fitting program.
- In practice, a major influence on referral decisions may have been how FFT fit with the personal schedules of the youth and family.

DIFFERENTIATING FFT AND MULTISYSTEMIC THERAPY (MST)

- There was some confusion at the program's inception as to what characteristics of youth and families make FFT a better service than others. Agencies particularly struggled in differentiating FFT from Multisystemic Therapy (MST) and third-party monitoring (monitoring was one of the more-often-used services before FFT was offered and thus referral sources had greater familiarity using it).
- The referral agencies invited service providers to discuss the differences between FFT and MST with coordinators and case managers to enable them to make informed referral recommendations. Despite this, there appeared to be some lingering uncertainty as to the elements that distinguished the two treatment models and the PFF program needs to invest continued work into educating those making referral decisions.
- At times, those who made referrals believed that MST handled more difficult cases and youth, while FFT was better-suited for youth and families that needed less intensive services, although this is incorrect. The differences between FFT and MST are examined in Box 1.

Box 1: Differentiating Functional Family Therapy from Multisystemic Therapy

FFT and MST have several similarities and differences.

Similarities

- Both FFT and MST are Model Programs as identified by Blueprints for Violence Prevention.
- Both focus on at-risk and system-involved youth, identified within juvenile justice or social service agencies. Both therapies identify at-risk or in-need juveniles (though MST requires an Axis 1 diagnosis for referral to this service),
- Both focus on family communication and interaction for long-term success and rely on therapist engagement with the family as well as flexibility in implementing a variety of techniques to address the presenting and underlying issues at work in the family.
- In both, the family is engaged and solicited to share their understanding of the problems. Strengths and weaknesses in the family as well as risk and protective factors are assessed. This information enables the therapist to construct a plan to address the underlying causes of the behavior while motivating the family members to be stakeholders in positive change.

Differences

- The defining difference between FFT and MST is the source of the stressors affecting family functioning. If the source is from within the family, FFT is the appropriate vehicle for therapy. If the source is external to the family but affects family functioning, MST is likely to be a better fit for families. If the family is the primary vehicle for these antisocial behaviors, FFT appears to be best-suited. If the source of the behavior is most influenced by forces external to the family (e.g., community, peer group, etc.), even if those forces affect the family relationship, MST appears to be the better option.
- MST views youth-family problems from an ecological perspective, examining how community, school, work, and peer factors influence behavior and cause deviance and other antisocial activities. In contrast, FFT focuses much more closely on the youth-family dynamic, largely ignoring the external community influences. MST identifies with parents, attempting to help them strengthen their parenting skills, curb youth problem behavior, and reshape youth networks into prosocial sources of support. FFT views the youth and family members as equals, each potentially having different stressors or motivations guiding their actions, but both equally accountable and both needing to be equally engaged and invested in change (Alexander et al. 1998).

Treatment

- FFT is a home-based therapy with a typical duration of treatment of around three months. Sessions begin more intensively with as many as two sessions occurring each week, then scaling down to one per week or every other week as the family progresses through the phases.

- MST is more intensive both in overall duration and frequency. A typical MST case will span approximately four months and provide approximately 50 hours of therapy time with families. FFT total session length is around 30 hours (Henggeler and Lee 2003). Unlike FFT, MST sessions are often held in the community instead of the home. MST sessions can be in the school or some other community meeting space. FFT's focus on the family necessitates home-based treatment (services do, on occasion, begin in a juvenile facility but only if the youth is soon to be released to a home placement). MST anticipates that crises can and will occur, thus therapists are available 24 hours per day in the event that a family needs to meet to avert an emerging crisis.
- MST incorporates components outside of the family. To the extent that problems at school (e.g., low achievement, lack of engagement, conflict between family and school personnel, or problems among youth and peers) affect the youth and youth-family functioning, MST sessions work on skills to build healthy and collaborative relationships, strengthen protective factors, and mitigate risk factors. Therapists can become more proactive in this regard by interfacing with the school when it appears conflicts cannot be appropriately addressed in sessions. When the problems arise in the community but outside of the school or are with youth peers outside of the school setting, the sessions and therapist interventions are similar. The sessions will focus on those experiences and related feelings that are negatively affecting the youth and/or family in the community and work towards developing ways to overcome them. As needed, therapists may interject themselves personally to help mitigate those stressors.

SERVICE PROVISION

- FFT is intended to be conducted in the family home. Stakeholders believe that home-based therapy engaged families more and demonstrated to them that therapists were invested in the family's success. Conducting sessions at the home also reduced the instances when families would cancel their appointments, citing reasons such as transportation hardships in commuting to the therapy site.
- Maintaining open and ongoing lines of communication was critical to the program's success. For example, if a youth was about to have a court date that would likely result in a commitment to confinement, the service provider should be informed. If done early enough, the treatment may be delayed until after the youth is released. If therapy has already commenced, the therapist can work to prepare the family for this significant disruption. Continuity between PFF partners, particularly between referral agencies and service provider, is essential for promoting success.
- Communication and information-sharing initially was a challenge for referral agencies and service providers; however, communication appeared to have improved over time.
- Lead entities often have a representative attend DYRS's youth-family team meeting to promote continuity and also to note what services currently have the capacity to enroll new families immediately.

- If a DYRS youth stops attending the sessions or is no longer placed in the community, service provision may terminate. However, the service provider, lead entity, and DYRS case manager work to engage the family before reaching this point. If the family has lost faith in the service or provider, the lead entity attempts to connect them with another service to see if there is any improvement.
- Lead entities schedule meetings with families 90 days after the referral to see if they are still invested in the service. This helped them identify problems earlier and take proactive steps to keep the family engaged or to find alternative services if the family felt unable to continue with the current service.
- PASS case managers were a central hub as the youth may be referred to several services; the manager ensures that they are coordinated and complementary. Further, this manager-family relationship often enabled the case manager to communicate information about the youth or family needs beyond what was found in the assessments, based on what was learned through personal interactions and communications.
- Therapist turnover has hampered both service providers. This problem persisted throughout the program and required continued attention.
- Parents often expected the agencies or therapists to “fix” their children without a willingness to work to help improve the youth and family functioning or acknowledging responsibility for the presenting problems. Case managers tried to manage expectations of parents thinking that one or more services could address all of youth’s needs in short order. Additionally, therapists continually engaged parents and caregivers to be equal partners in identifying contributions to the problems and equally responsible for working towards constructive solutions.
- Therapists had difficulties in reaching families within the target time from receipt of a referral (24 hours). Families often were not home for scheduled meetings or the address or phone numbers provided in the case file were incorrect.
- Both providers regularly had three therapists on staff and on occasion fielded a full staff of four. This translated into an organizational capacity of approximately 25 to 35 active cases. However, one therapist operated at half-capacity in each provider because of other supervisory responsibilities, reducing capacity to around 25 to 30 cases.
- Service providers reported that communication was an issue at first but improved over time.

4. Performance Data

This chapter reviews aggregate performance data obtained from the PFF partners. The data used in this evaluation is from the period of October 2009 through June 2011, although the program continued through September 2011. These data allowed us to examine client characteristics, referral sources and reasons, initiation, progress and completion of cases, attendance and participation, and therapist competence in FFT.

Three types of aggregate data were obtained. First, we obtained monthly referral numbers transmitted from service providers to EBA. As youth were referred and accepted into the program, PLC and SSC would transmit the number of referrals received by referral agencies and the number of referrals that were inappropriate and therefore not accepted. Staff reviewed aggregate quarterly data provided by FFT Inc. regarding service provider activities. These data tracked quarterly changes in key programmatic measures such as average number of sessions per month, average time to first family contact and first session, and successful completion, as well as therapist ratings of their competence administering the FFT model.

Second, the project team received aggregate data from service providers that is stored in FFT Inc.'s CSS database. This information reported a variety of demographic, provider, and case measures such as gender, referral reasons, and reasons for treatment failure.

Third, service providers also shared deidentified case-level data. These data provided key programmatic dates such as dates of referral, treatment commencement, and termination, as well some information on the youth and family's educational status and engagement with the community.⁸

REFERRALS

Table 4.1 illustrates the proportion of youth referred from each of the agencies. As can be seen, CFSA referred more than half of the program's youth, followed by DYRS. PASS referred the fewest youth, as might be expected given that PASS joined the PFF program approximately one year after the other two agencies. As can also be seen, referrals from DYRS declined considerably during the last three quarters. This is especially true for referrals to PLC.

⁸ UI attempted to obtain case-level information from the referral agencies for the evaluation; however, DYRS and CFSA were unable to provide this data, and PASS was migrating to a new electronic system which raised data integrity issues.

Table 4.1. Referral Source

Service Provider Referral Source	PLC (Wards 1–6)			SSC (Wards 7 and 8)			Citywide Total			TOTAL
	CFSA	DYRS	PASS	CFSA	DYRS	PASS	CFSA	DYRS	PASS	
Jan–Mar 2010	8	9		14	6		22	15		37
Apr–Jun 2010	19	11		30	14		49	25		74
Jul–Sep 2010	4	10		24	6		28	16		44
Oct–Dec 2010	14	1	11	10	15	14	24	16	25	65
Jan–Mar 2011	13	3	6	16	5	11	29	8	17	54
Apr–Jun 2011	3	2	6	10	9	8	13	11	14	38
TOTAL	61	36	23	104	55	33	165	91	56	312
% by service provider	51%	30%	19%	54%	29%	17%	53%	29%	18%	
TOTAL	120			192						

CLIENT CHARACTERISTICS

Table 4.2 displays gender, race, age, and educational and family status of youth enrolled in FFT, by service provider. Over 90 percent of the youth referred were between the ages of 11 and 18, in line with the FFT model. The majority of youth were male (67 percent PLC and 61 percent SSC), African American (over 80 percent), and from a single-parent household (over 65 percent). Most were enrolled in some sort of educational program, whether it be traditional schooling or in pursuit of a GED (over 85 percent). Within these general statements, there were some differences by geography; specifically, the referred youth in Wards 7 and 8 (SSC) were 98 percent African American.

Table 4.2. FFT Client Characteristics by Service Provider

		PLC: Wards 1-6 (# of referrals = 118)	SSC: Wards 7 and 8 (# of referrals = 175)
Gender	% Male	67%	61%
Races	% African American	80%	98%
Age	10 and Under	0%	4%
	11	0%	3%
	12	3%	5%
	13	5%	12%
	14	14%	9%
	15	19%	18%
	16	15%	20%
	17	18%	15%
	18	16%	9%
	Over 18	10%	4%
Education	Enrolled in school/GED	88%	94%
	Not enrolled in school	6%	1%
	Graduated/GED	3%	0%
	Other	3%	5%
Family Status	One biological parent	65%	78%
	Two biological parents	12%	4%
	Parent(s) nonbiological	14%	10%
	Other	9%	8%

Source: Urban Institute analysis of FFT Inc. CSS data provided by SSC and PLC respectively.

REFERRAL REASONS

An important consideration for the program evaluation is the reason youth are being referred. The primary reasons for referral are displayed by service provider, in table 4.3. It is important to note first that these referral reasons are choices in a drop-down menu that is entered by service providers after receipt of a referral, as part of FFT Inc.'s Clinical Services System (CSS) database. We categorized these reasons as concerning family issues, delinquency, school issues, and other, including substance abuse and mental health issues. (We opted to categorize "family violence" in the latter category because it is not clear what that family violence involves and if it involves the youth in any way.)

The largest group of referrals was for family issues, especially in Wards 7 and 8 (SSC), consistent with the goals of FFT. These were followed by school issues, primarily truancy, and

other. Although a small percentage of total referrals, it is worth noting that Wards 1 through 6 (PLC) received twice as high a percentage of referrals for substance abuse (6 percent versus 3 percent) and mental health (2 percent versus 1 percent).

Table 4.3. Referral Reason by Service Provider

Referral Reason	PLC: (Wards 1-6) (# of referrals = 118)	SSC: (Wards 7 and 8) (# of referrals = 175)
Family Issues	32%	45%
<i>Family relationship problems</i>	3%	1%
<i>Parent/child/parenting issues</i>	2%	1%
<i>Referred for family reunification</i>	7%	9%
<i>Referred for family separation</i>	0%	1%
<i>Referred for runaway behavior</i>	3%	4%
<i>Referred for youth/parent conflict (verbal)</i>	17%	29%
Delinquency Issues	26%	26%
School Issues	21%	18%
<i>Referred for school truancy/behavior</i>	20%	17%
<i>School-related problems (e.g., school behavior, learning problems)</i>	1%	1%
Other	22%	11%
<i>Referred for family substance abuse/use</i>	6%	3%
<i>Referred for family violence (physical)</i>	7%	7%
<i>Referred for mental health issue</i>	2%	1%
<i>Referred for other reason</i>	7%	0%

Source: Urban Institute analysis of FFT Inc. CSS data provided by SSC and PLC respectively.

Do referral reasons vary by referring agency? Table 4.4 presents the reported primary referral reason by both agency and service provider. Because the numbers are small, these figures should be interpreted with caution. For SSC (Wards 7 and 8), the referral reasons vary as might be expected. Fully 83 percent of DYRS referrals were for delinquency;⁹ most of CFSA's referrals were for family issues (63 percent); and PASS's referrals were split between family (60 percent) and school issues (40 percent). For PLC (Wards 1 through 6), these patterns are much weaker. We are unable to determine whether this difference by service provider is a reporting difference or represents a real difference, but it bears further examination.

⁹ While a reasonable response to the dropdown menu, choosing "delinquency" as the primary referral reason is not revealing about why FFT was chosen for DYRS-referred youth.

Table 4.4. Referral Reasons by Referring Agency

	CFSA	DYRS	PASS
PLC (N=104)	(N=64)	(N=24)	(N=16)
<i>Family</i>	31%	25%	31%
<i>Delinquency</i>	25%	29%	0%
<i>Truancy/school behavior</i>	20%	29%	50%
<i>Substance abuse/MH/family violence</i>	23%	17%	19%
SSC (N=151)	(N=84)	(N=42)	(N=25)
<i>Family</i>	63%	5%	60%
<i>Delinquency</i>	5%	83%	0%
<i>Truancy/school behavior</i>	18%	5%	40%
<i>Substance abuse/MH/family violence</i>	14%	7%	0%

Source: Urban Institute analysis of FFT Inc. CSS data provided by SSC and PLC respectively.

INITIATION, PROGRESS, AND COMPLETION OF CASES

We now consider how often cases are completed successfully, and why cases fail to be completed.

CASE PROGRESS

Table 4.5 displays case progress for all cases, by service provider, based on data entered by each service provider into FFT Inc.'s CSS database (containing both aggregate and some case-level information), for cases that were completed either successfully or unsuccessfully. Almost one-quarter (23 percent) of referred cases were not initiated into treatment, and almost half of cases dropped out after treatment initiation. As a result, only a minority of cases were completed successfully. If one includes cases that are not initiated in the calculation, then only 29 percent were completed, and if one excludes those cases, then 38 percent were completed.

Table 4.5. Case Progress by Service Provider

Service Provider	Referred but never began FFT	Dropped Out	Completed FFT	Completion rate, among those initiating treatment
ALL CASES (233)	23% (54)	111 (48%)	29% (68)	38%
PLC, Wards 1–6 (89)	21% (19)	55% (49)	24% (21)	30%
SSC, Wards 7 and 8 (144)	24% (35)	43% (62)	33% (47)	43%

We also see that cases served by SSC were more likely to be completed successfully than were those served by PLC. We have already seen that the caseloads of the two service providers were similar in terms of the referral agencies (table 4.2). However, there were some differences between the service provider caseloads in the primary referral reasons reported by case managers (table 4.3), with SSC receiving more referrals for family issues, and somewhat more SSC youth living with a single parent. Whether these differences contribute to or account for the differences among service providers in case completion is an important question. (Individual-level data would be necessary to explore these relationships further.)

Does case progress vary by referral agency? Table 4.6 breaks down case progress by referral agency, using data entered by each service provider into FFT Inc.'s CSS database. It is important to note that these data summarize case progress for the entire period. Because PASS began referring cases about a year later than CFSA and DYRS, after the process was more stable, their completion rates are not comparable to the other agencies.¹⁰

Comparing DYRS and CFSA cases, we see that a considerably higher percentage of DYRS than CFSA referrals are never initiated into treatment, and a higher percentage of CFSA than DYRS referrals have been successfully completed or are still active. Of course, in many respects the cases referred from the different agencies are quite different (see table 4.4). Thus, they might be expected to perform differently. Nonetheless, for implementation purposes, this raises important issues for the PFF program, and may suggest that youth and families referred from DYRS cases may need additional efforts and resources for initiating and retaining cases.

Table 4.6 Case Progress by Referral Agency

	Never began	Dropped out	Completed/ active
CFSA (N=148)	18% (27)	41% (61)	41% (60)
DYRS (N=66)	30% (20)	35% (23)	35% (23)
PASS (N=41)	12% (5)	32% (13)	56% (23)

Source: Urban Institute analysis of FFT Inc. CSS data provided by SSC (n=151) and PLC (n=104), respectively.

REASONS FOR FAILURE TO INITIATE FFT AND FOR DROPOUT

Why do cases fail to reach successful completion? Table 4.7 displays reasons for failure to initiate treatment and for dropout, by service provider, based on data entered by each service provider into FFT Inc.'s CSS database. These choices are selected by service providers from a drop-down menu much like the process discussed regarding referral reason selection. FFT Inc.'s CSS Guide distinguishes reasons for not initiating treatment from reasons for dropout. Many more PLC than SSC cases were administratively discharged before initiation. This may bear additional inquiry.

The largest contributors to dropout for both providers was an inability to contact the family, the family refusing to continue with therapy or moving, or the youth being placed out of the home. This seems particularly problematic for SSC, in Wards 7 and 8.

¹⁰ In addition, these data do not distinguish successful completion from active cases. Since PASS started referring cases later, a higher percentage of their referrals are still open cases.

Table 4.7. Reasons for Dropout and Termination

	PLC (N=51)	SSC (N=63)
Treatment not initiated	39% (20)	8% (5)
<i>Administrative discharge</i>	35% (18)	3% (2)
<i>Referred to other services</i>	4% (2)	5% (3)
Dropout	61% (31)	92% (58)
<i>Incarcerated</i>	6% (3)	8% (5)
<i>Moved/placed out of home</i>	16% (8)	28% (18)
<i>Runaway</i>	4% (2)	5% (3)
<i>Quit/could not contact</i>	35% (18)	51% (32)

Source: Urban Institute analysis of FFT Inc. CSS data provided by SSC and PLC respectively.

During semistructured interviews with service provider staff members and monthly conference calls among PFF stakeholders, these issues were routinely raised as challenges for the program. Anecdotally, stakeholders believed they improved in these areas as the program matured. Nevertheless, the low rates of successful completion for the program overall suggest that these issues need continued attention to prevent attrition of FFT clients.

CASELOADS

Both service providers reported that they employed between three and four therapists throughout the course of the program. Therapists maintained between 8 and 12 active cases at any time and each site's Team Leader carried 5 to 7 active cases.

TREATMENT INITIATION

How long does it take from case referral to contact clients, to obtain consent and open a case, and to conduct a first session? (Consent to treatment can occur during the first session, but also prior to the session as well.) FFT Inc. has set goals for service providers to contact families within two days of receiving the referral, to obtain consent and open the case within seven days, and to hold the first session within seven days.

As can be seen in table 4.8, these performance goals are not being met overall. SSC has been able to make the first contact—for cases that were initiated—within one day on average, but neither provider has been able to open cases or begin treatment, on average, within the target time.¹¹

¹¹ We might expect improvement in achieving these performance goals over time. However, preliminary inspection of data by fiscal year (not shown) did not reveal consistent improvement from FY10 to FY11.

Table 4.8. Days to Initiate Treatment

	N	Average Time from Referral to first contact	to case open	to first session
TARGET		2	7	7
	187	2.4	10.9	14.7
PLC (Wards 7 and 8)	79	4.4	9.4	13.0
SSC (Wards 1–6)	108	0.9	12.0	15.9

Source: Urban Institute analysis of FFT Inc. CSS data provided by SSC and PLC respectively.

FFT Inc. believes that early engagement and treatment initiation is important and will lead to better treatment participation. This raises the hypothesis that treatment completers will have faster start-up times than dropouts. Table 4.9 examines time to treatment separately for completers and dropouts. No consistent pattern emerges.

Table 4.9. Days to Initiate Treatment for Completers vs. Dropouts

	n	Average Time from Referral to First Contact	to Case Open	to First Session
PLC completers	25	4.4	14.0	14.2
PLC dropouts	54	4.5	7.2	12.5
SSC completers	45	0.6	9.7	13.3
SSC dropouts	63	1.2	13.6	17.8

NUMBER AND TIMING OF THERAPY SESSIONS

According to the FFT model, a successfully completed case should require approximately 12 to 14 sessions. Table 4.10 shows sessions attended, and sessions per month, by quarter. PLC averaged 13.2 sessions per client, although there was some variation over time, but SSC only averaged 10.6 sessions per client.¹²

FFT also specifies at least four sessions per month (i.e., once per week). The number of monthly sessions per family averaged 2.1 and 2.5 at PLC and SSC, respectively. Full fidelity to the model would require both providers to increase their number of sessions per month.

¹² These data come from the FFT Inc. 2nd Quarter Quarterly Adherence and Fidelity Report to PFF Program partners. We assume that this captures only cases resulting in completions. If it includes cases that terminated early or never began at all, then this may be biasing the average number of sessions downward.

Table 4.10. Number of Sessions by Service Provider

	PLC	SSC
Total # sessions (avg.) (Goal: 12–14)*	13.2	10.6
2010 Quarter 3	-	7.9
2010 Quarter 4	14.5	10.0
2011 Quarter 1	17.6	10.7
2011 Quarter 2	7.4	13.6
Sessions per family per month (Goal: 4)	2.1	2.5
2010 Quarter 3	2.6	1.8
2010 Quarter 4	1.9	1.7
2011 Quarter 1	1.9	2.5
2011 Quarter 2	2.1	3.8

Source: FFT Inc. 2nd Quarter Quarterly Adherence and Fidelity Report to PFF Program partners.

Assessments

FFT mandates that both participants and therapists complete assessments at the beginning of each treatment phase and at the completion of treatment. In the first session, families complete a Family Self Report (FSR) that assesses feelings about how the family is currently functioning, whether they feel a connection to the therapist, and their beliefs for the future. This assessment is readministered at the beginning of each new phase. Next the parents complete the Outcome Questionnaire (OQ) and the youth completes the Youth Outcome Questionnaire (YOQ). Both ask the same questions but one from the parent's perspective of the youth's behavior and the other from the youth him/herself. The answers to these questions help the therapist identify potential behavioral difficulties and to plan their goals for the subsequent phases and session plans accordingly.

Assessments are also administered at treatment completion to identify change. Posttreatment, the Client Outcome Measure assessment (COM-A for youth and COM-P for parents, who complete it separately) attempts to describe how the family has changed since engaging in FFT. The therapist also completes a posttreatment assessment, the Therapist Outcome Measure (TOM), which asks the same questions as the COM-A and COM-P, but from the therapist's perspective.

Table 4.11 shows the completion rates, by service provider, using data from the 2nd Quarter Quarterly Adherence and Fidelity Report for PFF service providers, generated by the PLC's and SSC's FFT Inc. consultant. At treatment completion, all participants completed their assessments, and almost—but not quite—all therapists. But during treatment, there is a clear gap in assessments, with 14% of assessments by clients missing from SSC clients, and over

30% missing from PLC clients. Whether this is due to lack of emphasis by therapists, lack of willingness by clients, or both, is a question that bears further examination.

Table 4.11: Assessment Completion

	Assessment Completion	SSC	PLC
At 1st session of each phase	by family (FSR)	86%	57%
	by parent/youth (OQ/YOQ)	86%	67%
At completion of therapy	by therapist (TOM)	98%	94%
	by youth (COM-A)	100%	100%
	by parent (COM-P)	100%	100%

Source: FFT Inc. 2nd Quarter Quarterly Adherence and Fidelity Report to PFF Program partners.

THERAPIST ADHERENCE AND FIDELITY

How well is FFT being delivered? How well are therapists adhering to the program model and requirements?

As part of its quality control, FFT Inc. has therapists rated on adherence to program requirements and fidelity to the FFT therapy model. Therapist adherence and fidelity are broad and somewhat subjective measures of competence in the model. Ratings are initially made by an FFT consultant, later transitioning to the team leader generating the ratings in consultation with the FFT consultant.

The adherence rating comes from the consistent completion of progress notes, contacts and documentation of contacts with the family, and administration and completion of FFT assessments.

Therapist fidelity is based on therapist performance in administering the therapy. It measures what the therapist actually did in sessions each week, determining whether the therapist had a clear plan for the sessions, used the appropriate techniques given the family situation and the current phase, or was able to introduce new interventions given the changing dynamics of the session.

Table 4.12 displays average adherence and fidelity for each service provider, by quarter, through the second quarter of 2011. Overall, SSC has consistently met the adherence target of 4.0, but PLC has achieved that target in only one quarter. As these are largely administrative requirements, given a commitment to their completion, there appear to be few barriers to raising these figures.

On therapist fidelity, SSC has been consistently close to the performance target of 4.0, but has met it only occasionally. PLC's fidelity scores have been lower, but they have steadily improved over time.

Table 4.12. Therapist Fidelity Measures by Service Provider

	PLC	SSC
Therapist adherence (Goal: 4+)		
Site average	3.48 (103)	5.08 (103)
2010 Quarter 2	2.70 (10)	4.86 (14)
2010 Quarter 3	4.04 (25)	4.64 (22)
2010 Quarter 4	3.54 (24)	4.85 (27)
2011 Quarter 1	3.72 (18)	5.53 (15)
2011 Quarter 2	3.42 (26)	5.52 (25)
Therapist fidelity (Goal: 4+ in 1st year)		
Site average	2.75 (103)	3.82 (103)
2010 Quarter 2	1.90 (10)	4.07 (14)
2010 Quarter 3	2.60 (25)	3.82 (22)
2010 Quarter 4	2.88 (24)	3.52 (27)
2011 Quarter 1	3.11 (18)	3.67 (15)
2011 Quarter 2	3.27 (26)	4.04 (25)

Source: Urban Institute analysis of FFT Inc. CSS data provided by SSC and PLC respectively.

COMPARISON TO OTHER PLACES

How does D.C.'s implementation compare to another location's experiences? Previous evaluations of FFT have almost exclusively looked at outcomes, often failing to enumerate various programmatic elements of the program. Thus, it is difficult to position this D.C. PFF program in the context of other places that have instituted the program. For example, we know the FFT's goal for time from referral to first session is seven days or less; however, we have relatively little knowledge of whether other sites routinely meet that goal.

Table 4.13 attempts to place D.C.'s program with what is known from other places. Compared to other sites, D.C. keeps families in therapy for a longer period of time while seeing them less. Following the model strictly, families would start and end within 10 to 12 weeks. D.C. doubles that amount; however, it appears other sites have struggled with this as well.

The study by Breuk et al. (2006) was the only one to report on adherence. The D.C. program did exceptionally well comparatively, though the Breuk numbers reflect the adherence ratings of the first six months of the program's implementation. Over their first two quarters, however, PLC and SSC had combined adherence ratings of 4.20, suggesting that D.C.'s program may have actually been implemented with better adherence.

Finally, D.C.'s family status roughly aligns with that found by Gordon et al. (1988). As the therapy targets youth with juvenile justice system contact, risk of contact, or contact with another system, and single-parent status is often present in families with these characteristics, it is not altogether surprising.

Table 4.13. FFT Programmatic Literature

	Duration (weeks)	Number of sessions	Adherence	Family status
D.C. PFF PROGRAM	25.2	6.4 overall (9.2 for completers)	4.28	72% single biological parent
Alexander, J.F., Parsons (1973)	10	8		
Gordon et al. (1988)	22	16		60% single-parent household
Sexton and Turner (2010)	12-24	12		
Gordon, A., Graves, K., Arbuthnot, J. (1995)		16		
Waldron et al. (2001)		8		
Barton et al. (1985)		10		
Breuk et al. (2006)			2.5-3.5	

5. Conclusions

EVIDENCE-BASED PRACTICES AND FFT

FFT is an evidence-based program (EBP) that has been evaluated repeatedly, in evaluation studies of high rigor, and shown to reduce delinquent behavior. As a result, it is on the Blueprints for Violence Prevention list of effective programs. The wealth of prior research and evaluation supporting its effectiveness makes FFT an attractive service to be offered to appropriate D.C. youth and families. It also has an associated dissemination organization—FFT Inc.—that provides training, consultation, and certification.

One of the strong benefits of adopting such EBPs is that there is a strong assumption that the effects already demonstrated elsewhere can be realized, provided that the intervention is implemented well. This stands in contrast to the primary evaluation question for a newly developed intervention, or one that is not manualized and standardized. There we must start with a more skeptical stance, and cannot assume that the intervention will deliver the hoped-for impacts, even if well implemented. In the current evaluation, given FFT's prior evaluation base, the premium has been on evaluating implementation rather than in mounting an outcome evaluation of high rigor.

PFF IMPLEMENTATION FINDINGS

The goal of this evaluation was to understand the planning, implementation, and execution of the Put Families First program as it administered Functional Family Therapy in the District of Columbia. The primary question is whether FFT has been implemented with high fidelity and quality and whether there are local factors or circumstances that either facilitate or interfere with its reliable implementation.

This evaluation reviewed programmatic manuals and materials, engaged in semistructured interviews, analyzed performance data, and scanned the extant FFT programmatic and outcome literature. Through these activities, this report documented how the program came together, identified its key stakeholders and their role in the process, and used performance data to examine how the program appeared to be progressing along a number of key measures.

STRENGTHS

Management oversight and buy-in are key qualities that the program already possesses. EBA guided the original planning discussions, led troubleshooting efforts as barriers arose, attempted

to look to the future to anticipate and avoid future problems, and instituted changes that would be beneficial moving forward.

The program partners were all committed to the program as well. They identified representatives that had leadership and supervisory roles in their respective agencies and had the authority to implement change. Within the regular stakeholder meetings, partners would routinely try to help solve problems, even when they did not affect their organizations directly. Commitment and belief in the model and its implementation are critical factors.

REFERRALS

The referral *process* seemed to operate largely as envisioned and the number of referrals anticipated was roughly being received. About half of the referrals were from CFSA.

Although the referral mix from agencies to the two providers was similar, with over half of referrals to each provider coming from CFSA, we find different *reasons* for referrals from the agencies to the two service providers. The pattern of reason for referral by agency is much more as expected for SSC than PLC. For SSC (Wards 7 and 8), most referrals from CFSA were for family reasons, most referrals from DYRS were for delinquency, and PASS referrals were split between family and school-related issues. However, this pattern was less clear for the youth referred to PLC (Wards 1 through 6), where both CFSA and DYRS referrals were more varied in reason, and more similar to each other.

Such apparent differences between SSC and PLC referrals in reasons for agency referral reflect differences in recording practices, differences in the agencies' clients in different areas of the city, or differences in services other than FFT that are available to youth in different areas of the city. We are unable to distinguish these possibilities here, but understanding them may be important for understanding the differences in treatment initiation and treatment completion between the two service providers, and improving implementation outcomes for PFF.

TREATMENT INITIATION AND COMPLETION

A considerable number of referrals never initiated treatment (about one-quarter of cases), and almost half of those initiated dropped out before completing treatment. While noninitiation was somewhat more frequent at SSC, dropout was considerably more likely at PLC. Overall, SSC cases were more likely to be completed. When the reasons for dropout and termination were examined, the patterns were somewhat different by service provider.

In addition, the program fell short of a series of benchmarks: time to initiating therapy averaged about twice as long as the target of seven days; and therapy involved somewhat fewer sessions than the target goal, but at a slower pace than the program benchmark. However, therapy adherence and fidelity seemed largely on track, although there were differences by service provider. Adherence seemed to exceed the one published report that we were able to find.

ADHERENCE AND FIDELITY

Performance indicators, too, varied by service provider. While PLC was on track for the number of sessions provided, by the end of the second quarter of 2011, SSC too was on track. By that time, SSC seemed to close in on the number of sessions per family month recommended by FFT Inc. On a number of other indicators, SSC seemed to meet or be close to meeting performance benchmarks, including completion of assessments at first sessions and at the completion of therapy, therapist adherence, and therapist fidelity. PLC was progressing on these benchmarks, but has further room for improvement.

Because service providers are geographically bounded, we caution that such differences may reflect a combination of service provider performance and differences in the caseloads served by the two providers. Moreover, the pattern of referral reasons is more in line with expectation for SSC than PLC. The available data do not allow us to tease apart these issues.

SUMMARY

The implementation results to date suggest that the FFT program was implemented rigorously and is on its way to effective implementation, but has some challenges yet to overcome. The apparent differences between service providers provide an obvious starting point for inquiry to identify opportunities for such improvement.

The lack of a national data set on FFT implementation prevents a comparison of the District's experience with national norms, and therefore the description of the implementation experience is necessarily somewhat qualitative in nature.

However, the FFT dissemination organization—FFT Inc.—has established performance standards, which is a strength of the program. Absent such benchmarks, we would have little basis for assessing whether the program's performance was better or worse than expected. With these performance benchmarks in hand, we find that one service provider seems at or close to performance benchmarks for adherence and fidelity and the other has been approaching those benchmarks.

CHALLENGES AND RECOMMENDATIONS

PROGRAM INITIATION AND COMPLETION

Among the program data/variables monitored in this evaluation, the completion rates were not as high as was hoped, and the large drop-off from referral to successful program completion is a reason for concern and further exploration. Two important and interrelated questions for further exploration concern the reasons for program noninitiation and dropout, and whether there are systematic differences in referrals for those who were referred but never began the program, those who initiated but dropped out, and those who successfully completed the program.

COMPLEXITY OF THE REFERRAL PATTERNS FOR PFF

The complex referral patterns make the PFF program more complex than many other FFT evaluations. Referrals come from three different agency sources, presumably with somewhat different clientele and referred for somewhat different reasons. These clients in turn are referred to two different service providers operating in different areas of the city in which there are different alternative programs and services available. Notably, the reasons for the decline in FFT referrals may bear further investigation.

The surprising difference between the referral reasons from the same agencies to the two different service providers (table 4.4) suggests that the mix of cases and clients in these different referral streams may also be different. Further investigation of the relationship between referral source, referral reason, service provider, and reasons for noninitiation or noncompletion may help to shed light on these patterns in ways that could improve performance. (The available data do not examine these issues in more detail; see footnote 7.)

These patterns also suggest that different steps may be necessary for the different referral streams to improve treatment initiation, adherence and fidelity, and completion.

STAFF

In addition, reducing the rate of staff turnover in PLC and SSC could potentially improve all of these areas as understaffing could lead to underperforming.

Similarly, better educating referral agency staff who interact with families could enable them to more effectively begin engaging families earlier and also to manage participating family members expectations more effectively.

FUTURE EVALUATION ACTIVITY

Given the default presumption of program effectiveness that follows from the prior studies of FFT in large scale randomized clinical trials, the obvious next step is to continue to work aggressively to improve program initiation, completion, and effective implementation in order to obtain the level of outcomes obtained in those RCTs.

Once effective implementation of an EBP like FFT is achieved, D.C. may want to verify that the EBP is achieving the expected impacts (on delinquency outcomes) that have been found elsewhere. This would require, first, the ability to obtain data on the desired outcomes for FFT participants, whether from administrative databases or data collection. The key outcome that is common across the referral agencies involved in PFF seems to be out-of-home placement. That is, PFF is intended to prevent out-of-home placement of its participants. For CFSA, this might also be a primary outcome. But for DYRS, this would presumably be an intermediate outcome, itself expected to reduce the primary outcome of reoffending. The second requirement for evaluating the impact of FFT on the outcome of interest is the establishment of a comparison population against which to gauge the outcomes of participants. How some of this might be accomplished is discussed in an accompanying memo on the Evaluability Assessment of PFF.

A third area of evaluation activity involves an estimate of the expected financial returns of the program (cost-benefit evaluation, CBA). CBA requires an estimate of program effectiveness, which is combined with cost analysis. For a new program, this estimate of effectiveness requires a rigorous impact evaluation in order to gauge the program's effects. However, for an EBP with substantial prior evidence of effectiveness, the prior evidence of the range of program effectiveness can be combined with local cost analysis. The local cost analysis considers the cost of the program under evaluation (FFT), and the costs of business as usual (or alternative programs).

For such a CBA, implementation effectiveness becomes key. That is, based on the range of effects found from prior studies, one can calculate the expected return on investment in the program—given the level of effective implementation. We briefly consider two ways in which implementation problems will affect CBA results. First, assume, for example, that the current program is only able to initiate treatment for three-quarters of referrals, and only to complete the program for half of all referrals. While the costs of the program involve any efforts involved with all referrals, we may anticipate benefits only for those who complete the program. This means that if there are any program costs accrued in trying to get referrals to initiate and complete treatment, all of those costs will ultimately accrue to only those who complete the program.

Second, if the program as implemented only achieves program benchmarks for a subset of program participants, then we assume that benefits will be reduced for those receiving a lesser version of the program. Some discount must be applied to the anticipated benefits for those participants.

SUMMARY

The current implementation evaluation shows promise for the effective implementation of FFT for youth at risk of out-of-home placement in DC. For those who do complete the program, implementation is generally close to program benchmarks and showing improvement. Some areas needing improvement were also identified, especially concerning the program's ability to engage and retain the referred youth through program completion, and concerning understanding the reasons for agency referrals.

Prior evidence of program effectiveness in reducing delinquency suggests that the current program has strong potential for being an effective part of the service mix for these youth and their families.

Future evaluation activity should continue to focus on improving program initiation, effective implementation, and program completion. This would then set the stage for either a rigorous impact evaluation or a cost-benefit analysis based on combining local cost analysis with evidence of program effectiveness from prior evaluations of FFT.

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Appendix A. Summary of Prior FFT Outcome Evaluations

Reference	Assignment	Population	Sample	Age	Follow-up period	Outcomes
Alexander, J.F., 1971; Alexander, J.F. and Barton, 1976,1980	Random Assignment	Delinquent Youth	40 (10 FFT; 30 comparison)	13–16	10 weeks	Social: Significant increase in communication
Alexander, J.F. and Parsons, 1973	Random Assignment	Delinquent Youth	86 (46 FFT; 40 comparison)	13–16	6–18 months	Recidivism: Significant reductions compared to comparison groups (21–47%) [chi-square = 10.25; df=3] Social: Reduced negativity, increased communication
Barnoski, 2002	Random Assignment	Delinquent Youth	527 (204 FFT; 323 comparison)	-	12 months	Recidivism: 30% reduction in treatment group
Barnoski, 2004	Random Assignment	Delinquent Youth	700 (387 FFT; 313 comparison)	13–17	18 months	Recidivism: No statistical difference on violent, felony, or misdemeanor recidivism. Controlling for therapist competence demonstrates 38% reduction in felony recidivism
Barton et al., 1985	Non-Random Assignment	Delinquent Youth	Study 1: 27 (27 FFT; used District base rates for comparison); Study 2: 325 (109 FFT; 216	-	Study 1: 13 months Study 2: treatment termination	Study 1: Recidivism: 26% recidivism rate significantly lower than 51% rate for juvenile court district Study 2: Social: Reduction in foster-care placements among FFT (11%) against comparison (49%)

Reference	Assignment	Population	Sample	Age	Follow-up period	Outcomes
			comparison) Study 3: 74 (30 FFT; 40 comparison)		Study 3: 15 months	Study 3: Recidivism: Reduction in re-arrest for FFT (60%) against comparison (94%). Reanalysis at 30 months showed no significant differences.
Friedman, 1990	Random Assignment	Drug-Abusing Youth	166 (91 FFT; 75 comparison)	17.8 (avg.)	15+ months	Social: Greater parent involvement
Gordon, A., Graves, K., and Arbuthnot, J., 1995	Non-Random Assignment	Delinquent Youth	54 (27 FFT; 27 comparison)	15.4 (avg.)	28 months	Recidivism: 32% reduction in treatment group [treatment: 8.7%, 8.5 SD; comparison 40.9%, 8.8 SD]
Klein, N.C., Alexander, J.F., and Parsons, B.V., 1977	Random Assignment	Siblings of Delinquent Youth	86 (46 FFT; 40 comparison)	13–16	30–40 months	Recidivism: Significant reductions among <i>siblings</i> (20% compared to 40–63% of various comparisons)
Parsons, B.V. and Alexander, J.F., 1973	Non-Random Assignment	Delinquent Families	40 (20 FFT; 20 comparison)	14.1 (avg.)	End of treatment	Social: Significant reductions in negative communication behavior [$F(1,36) = 6.95-16.20$]
Sexton and Turner, 2010	Random Assignment	Delinquent Youth	917 families (1:1 treatment-control matching)	13–17	12 months	Recidivism: No statistical difference between FFT and control condition. Controlling for therapist adherence to FFT demonstrates 43–57% reduction in

Reference	Assignment	Population	Sample	Age	Follow-up period	Outcomes
						overall recidivism and felony recidivism
Waldron et al., 2001	Random Assignment	Drug-Abusing Youth	120 (30 FFT; 90 comparison)	13–17	4–7 months	Drug: Significant reductions in marijuana use [$F(1,28) = 20.42$]

Appendix B. Put Families First: FFT Implementation Manual

Implementation Team

D.C. Justice Grants Administration

Evidence-Based Associates (EBA)

Functional Family Therapy Inc.

The Progressive Life Center and the Student Support Center

Working FINAL Edition

March 2011

Project Manual

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Program Overview

The family-focused, evidence-based service model chosen for this initiative is Functional Family Therapy (FFT). FFT is an empirically grounded, well-documented and highly successful family intervention program for youth engaged in the juvenile justice or child welfare systems. FFT has been applied to a wide range of problem youth and their families in various multiethnic, multicultural contexts. Populations of focus range from at-risk preadolescents to youth with very serious problems such as conduct disorder, violent acting-out, and substance abuse.

FFT focuses on youth age 11 to 18 and their parents/guardians. Younger siblings of referred adolescents often become part of the intervention process as well. On average, the intervention ranges from 8 to 12 one-hour sessions for mild situations and up to 30 sessions of direct service for more complex or difficult situations. In most programs, sessions are spread over a three- to four-month period. FFT focuses on providing intervention in the family's home and other settings comfortable for family members.

I. Program Level Information

a. Put Families First overview

- i. PFF is a JGA initiative designed to provide intensive family-based services for youth involved with D.C.'s Department of Youth Rehabilitation Services (DYRS), DHS's PASS program, or Child and Family Services (CFSA). These services are intended to prevent out-of-home placement of youth, or as support and stabilization for youth returning from out-of-home placement.

b. Programmatic components

- i. Two private nonprofit mental health providers, the Student Support Center (SSC) and the Progressive Life Center (PLC), will become certified FFT provider sites with a clinical team at each agency of at least three full time clinicians.
- ii. These two providers will serve approximately 200 families through Functional Family Therapy in FY 2010 and 2011.
 - a. The **Student Support Center** will serve 100 youth and their families living in Wards 7 and 8 of the District, and youth committed to city custody who live in appropriate placements in Prince George's County, Maryland.
 - b. The **Progressive Life Center** will serve 100 youth and their families living in Wards 1 through 6 of the District, and youth committed to city custody who live in appropriate placements in Montgomery County, Maryland.
- iii. D.C. government agencies and community providers will have enhanced knowledge of Evidence-Based Programs and the requirements associated with successful implementation.

- c. Population of Focus to receive services
 - i. Put Families First will serve youth (and their families) who are engaged with D.C.'s Department of Youth Rehabilitation Services (DYRS), DHS's PASS program, or Child and Family Services (CFSA).
 - ii. The youth can be legally committed to the above agencies or involved with their programming through other legal status.
- d. Program goals for population of focus
 - i. Youth are able to remain in their home setting, without disruption during FFT treatment.
 - ii. Youth commit no new criminal offenses while in treatment.
 - iii. Families have no new allegations of abuse or neglect while in treatment.
 - iv. Youth and families' functioning improve while in treatment.

II. Population of Service Criteria

- a. Inclusionary criteria
 - i. DYRS youth can be in precommitment (postadjudication) or committed status; CFSA youth/family can be at any phase of contact with CFSA; any youth enrolled in PASS are eligible.
 - ii. Youth has been identified as appropriate for community placement by agency and/or court.
 - iii. Youth is living with parent/caregiver at time of referral OR has a documented plan to move to parent/caregiver home within approximately 60 days of referral. FFT services can begin 30 days prior to family placement.
- b. Priority : Initial outreach efforts and waitlist priority will be given to youth who are
 - i. being diverted from RTC or other institutional placements;
 - ii. coming home from RTC or other institutional placements;
 - iii. dual- jacketed (DYRS, Probation, and CFSA).
- c. Exclusionary criteria
 - i. Youth living in nonfamily settings with no plans to move into a family setting within 60 days.
 - ii. Youth for whom a primary caregiver cannot be identified despite extensive efforts to identify extended family, kinship care, and other surrogate caregivers.
 - iii. Youth in active therapeutic family treatment; FFT should be lead intervention during treatment phase; youth in individual therapy will be considered by FFT provider on a case-by-case basis; exclusion does not apply to medication management.

- iv. Youth with a severe psychiatric illness such that they are actively suicidal or homicidal or demonstrate acute psychiatric conditions that require constant supervision and monitoring.
- v. Youth who have committed a sexual offense and have not received specific treatment for this offense, and where that sexual offense is not part of a pattern of other delinquent and antisocial behavior.

III. Referral and Case Initiation Process

- a. DYRS referral process (youth may be in a facility or in the community)
 - 1. DYRS worker, Lead Entity Representative from ERCPCP or PLC, and Re-Entry Coordinator (when appropriate):
 - a. Participate in a Youth Family Team Meeting (YFTM) with family and other stakeholders when
 - i. youth reaches **Level 4** (approx. 60 days prior to discharge) at New Beginnings or out of state placement OR
 - ii. youth is ready for discharge from a facility
 - iii. youth in community is referred for a YFTM and link to a Lead Entity.
 - b. At YFTM, FFT is discussed and, if appropriate, family agrees to participate.
 - c. Referring worker (Lead entity and/or DYRS worker) is responsible for ensuring family understands FFT referral is being made and they open to initiating service.
 - d. Lead Entity representative, working with DYRS worker, completes the **Request for Services** (appendix a) form and e-mails/faxes it to the designated FFT provider (at least 30 days prior to youth's discharge, at Level 4 YFTMs).
 - e. DYRS is not currently referring youth in precommitment status to FFT. This will be revisited in the future.
- b. CFSA referral process

FFT referrals will be generated primarily out of Family Team Meetings

 - i. The CFSA (or contract) worker and the FTM Coordinator should discuss FFT with the family prior to FTM if possible.
 - ii. Referring worker responsible to ensure that family and team assent for FFT services is achieved; this worker (CFSA or contract social worker) completes the **Behavioral Services Unit Referral form** (appendix b), specifies FFT as the request, and submits form to the Office of Clinical Practice (OCP).
 - iii. OCP reviews the application and if complete and appropriate submits it to the providers (details below).

- c. PASS Referral Process: PASS worker responsible to ensure that family agrees to participate, or at least meet with, FFT.
 - i. PASS case worker submits a referral directly to the appropriate FFT provider depending on the home address of the youth.
- d. Minimal information required with all FFT referrals
 - 1. Family contact information—several possibilities, especially if no main phone in home
 - 2. Brief social history—should include reasons for referral and specific concerns to be addressed
 - 3. Information on any current services the family is participating in
 - 4. Incomplete referrals will be returned to the agency by the FFT providers; no services initiated until minimum referral information is received by providers

e. Referral contacts

Youth in or returning to Wards 7 and 8, committed youth living in Prince George's County, MD:

Program Supervisor at the Student Support Center: **Sesilia Conchola**
sconchola@studentsupportcenter.org

FAX: (202) 628-8849

Youth in or returning to Wards 1 through 6, committed youth living in Montgomery County, MD:

Program Supervisor at the Progressive Life Center: **Mark Boothe**
mboothe@plcntu.org

FAX: (202) 842-0604

If electronic submission is not possible, fax the materials to the numbers above and send an e-mail notifying of the incoming referral.

- f. Provider communication with referral source
 - i. Within *two business* days of receipt, the FFT Provider (SSC or PLC) will e-mail the referring party with notice that the referral
 - ii. Is accepted (appendix c); or
 - iii. Requires more information, with specifics (appendix d); or
 - iv. Is inappropriate for the following specific reasons (appendix e).

g. **Accepted referrals**

- i. FFT clinician will make phone contact with the family within 48 hours of accepting referral, to make introduction and solidify the initial meeting.
 - ii. Assigned FFT clinician will conduct face-to-face meeting with youth and family within seven days of accepting referral.
 - iii. If attempts at phone contact by FFT clinician are unsuccessful, FFT will make a drop-in visit within four business days of accepting a referral.
 - iv. A minimum of two drop-in attempts, active partnership and information sharing with Lead Entity rep, DYRS or CFSA worker, a letter sent to family, and consultation with national FFT coaches will be explored by FFT clinician before family referral is returned to Lead Entity as “unavailable for service.”
 - v. Once a family has begun service with FFT, the FFT clinician will attend any family team meetings that are held by any referring agency. They may attend court hearings at the request of the family or the referring worker.
- h. **Caseload communication after initiation of treatment**
 - i. FFT clinician commits to a weekly phone call or brief e-mail to Lead Entity representative and DYRS, CFSA, or PASS worker to update on status of referral (attendance, participation). This call is also intended to build connection between the FFT provider referral workers to ensure better team work and communication for families.
 - ii. Monthly call (minimally) will be held between DYRS (RMUD), ERCPCP, SSC, PLC (clinical and Lead Entity), CFSA (OCP), PASS, and EBA to review referrals and referral process and further refine and learn from the process (to be scheduled and maintained by EBA).
- i. **Wait List**—when a provider is serving their full clinical capacity of families, new referrals will be placed on a wait list. This wait list will be reviewed by the provider and the referral source contacts on a weekly basis.
 - i. The provider supervisor will verify appropriateness of the referral; that there are no available clinical slots; there will not be any openings for more than 48 hours after receiving referral.
 - ii. Supervisor will place referral on Wait List by completing the Wait List spreadsheet, detailing any priority category that the referral may meet.
 - iii. Supervisor will send e-mail, attaching the Wait List memo (appendix f) to:
 - 1. CFSA: Referring worker and BSU rep: **Shameka Abney**, Shameka.abney@dc.gov
 - 2. DYRS: Referring worker and Lead Entity Rep: **Kim Hinton** (ERCPCP) kim_hinton@hintonconsultinggroup.com or **Constance Causer** (PLC) ccauser@plcntu.org

- 3. PASS: Hilary Cairns or staff designee hilary.cairns@dc.gov
- iv. Once a wait list is established, before moving a family off the wait list and into active status, the provider will consult with the agency designee of the next name on the list. The referral agency designee can move any of their referred families or a new referral into the top spot.
- v. *After the above process is complete*, the provider supervisor assigns the designated youth on the wait list to a clinician. E-mail confirmation of the case assignment will be sent to:
 - a. CFSA: Referring worker and Shameka Abney (BSU) the CFSA or DYRS referring worker
 - b. DYRS: Referring worker, and Kim Hinton (ERCPCP) OR Constance Causer (PLC)
 - c. PASS: Hilary Cairns or designee
- vi. That youth will be removed from the wait list.

IV. Program Guidelines and Procedures

- a. Guidelines for length of treatment
 - i. FFT is a short-term, high quality intervention program with an average of 12 sessions over a three- to four-month period.
 - ii. Individual sessions are scheduled between the FFT clinician and the family, based on their available time and the families' needs. Several sessions per week may be held in the early weeks of treatment.
- b. Discharge and termination of treatment criteria
 - i. "Relentlessness" is a core skill and behavior for FFT clinicians. Successful FFT providers must be relentless in their attempts to engage families in treatment.
 - ii. FFT, through the Put Families First program, is ultimately a voluntary program for families.
 - iii. As a general guideline, FFT clinicians should make many phone calls at different times of day, and make at least three (3) home visits (leaving written notice) before determining that a family is not available for treatment.
 - iv. If a family initially engages in treatment, but then stops responding to the FFT clinician, many phone calls at different times of day, and at least two (2) home visits, as well as approval from the national FFT consultant is required before discharging the family from FFT services.
- c. Discharge procedures
 - i. After the above steps are complete, a written letter should be sent to the family, with the explanation that their FFT case will be closed unless they contact the clinician and affirmatively state that they want to continue services, within ten (10) days of the letter's date (appendix g).
- d. Court reports and appearances

- i. As a general practice, FFT clinicians do not testify in court proceedings. The monthly reports that they submit to the referring worker contains a basic summary of FFT services that can be included in the workers court reports.
 - ii. Some situations will require a case-by-case review and determination by the FFT clinician, their supervisor, and their FFT consultant (if applicable). Situations that may warrant this individual review may include a family member specifically requesting the FFT clinicians' attendance, or contradictory information has been shared and FFT clarification is needed for the judge and other decision makers in the case.
- e. Unusual Incident (UI) reporting protocol
 - i. Each FFT provider agency has established UI reporting protocols which should be followed for any UIs that occur in the course of FFT treatment.

V. Treatment Team Reporting and Communication Procedures

- a. Clinical notes—All FFT clinicians keep their clinical notes from all family contacts in the Client Services System (CCS), FFTs online data/case management system.
- b. Weekly Referral Census—Each FFT team sends a weekly census report to the PFF program director (appendix h). This weekly census gives demographic information on each referral received from each referral source and details whether the referral was accepted or not. This weekly report helps the sites and the program director keep track of referrals and available spaces at every program site, which is gathered in the Weekly Referral Total report (appendix i) and shared with all program partners.
- c. Monthly Summary—Each FFT clinician sends a monthly summary to the referring worker for each family in their case load. DYRS monthly updates will be submitted through their YES online data system. CFSA and PASS updates will be submitted by e-mail to each worker (appendix j).
- d. DYRS—Youth Family Team Meetings (YFTM) and Lead Entities
 - i. Progressive Life Center Lead Entity
 - 1. PLC has contracted with the Columbia Heights/Shaw Family Support Collaborative, the Edgewood Brookland Family Support Collaborative, and the Georgia Avenue/Rock Creek East Family Strengthening Collaborative to provide ongoing Family Team Meetings for youth and families served through the PLC Lead Entity.
 - 2. FFT clinicians will attend and participate in FTMs that are held while the family is in active FFT treatment.
 - ii. ERCPCP Lead Entity—ongoing case management through the life of the DYRS case.
- e. CFSA—Family Team Meetings
 - i. CFSA and their contract agencies (including the Collaboratives) will hold Family Team Meetings (FTMs) throughout the life of a CFSA case, especially prior to a change in placement or other disruption.
 - ii. FFT clinicians will attend and participate in FTMs that are held while the family is in active FFT treatment.

Put Families First will continue to develop over the coming years. This may include creating additional FFT teams or growing the current teams. It may also include the addition of other evidence-based practices.

This policy and practice manual will continue to develop and evolve with the program.